Private Payer Initiatives to Refocus Systems of Payment

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Background on payment systems

- **Traditionally, payment systems fee-for-service**
  - Providers paid based on volume of services provided
  - Potential incentive to provide more services: the more services provided, the more provider is paid
- **Managed care move to capitated systems**
  - Intended to promote efficiency (onus on physician to provide 'appropriate' bundle of services)
  - Because payment is capped regardless of services provided, potential incentive to provide fewer services

Motivation for incorporating quality

IOM report *Crossing the Quality Chasm*, recommendations:

- Examine current payment methods to remove barriers that impede quality improvement
- Incorporate stronger incentives for quality enhancement—i.e., reward physicians for practices that improve patients' health

The Leapfrog Group:

- Based on principles of value-based purchasing
- Use of incentives and rewards to stimulate better, more efficient care

Bridges to Excellence:

- Rewarding physicians for the right clinical behaviors, while driving care process changes that promote the delivery of high quality healthcare service

First-generation systems

Credentialing or Tiered Networks

- Plans credential providers or define provider tiers based on various measures:
  - Prices
  - Efficiency (cost per episode of care)
  - Quality (less often)
- Often linked to reporting initiatives intended to promote informed decision-making by patients
- Based on recognition, but not directly linked to payment: patients rewarded with lower premiums or co-pays for seeking out top-tier providers

Pay-for-Performance (P4P, aka P4Q)

Emerged in mid-1990s: Based on reporting of data related to meeting standards of care

- Process—
  - Receipt of preventive screening such as mammogram
  - Electronic recordkeeping
- Service—
  - Patient satisfaction ratings
  - Weekend or evening hours
- Outcomes—
  - Clinical measurements such as lower cholesterol, HbA1c control, or re-admission rates

P4P, continued

Initially focused on PCPs and HMOs, gained most traction w/ HMOs (80%, reported in NEJM)

- Becoming more widespread nationally with private payers, expanded to hospitals and some specialists, but frequently still in planning or pilot phase
- At CMS—Medicare Physician Quality Reporting Initiative, est. 2006
- Direct link to payment: percentage increase in fee schedule (1.5-7%) or PMPM (~$2.25, higher for specialists)
- Still layering payment on FFS system

Medicare Physician Quality Reporting Initiative (PQRI)

Genesis

- Tax Relief and Health Care Act of 2006 authorized the initiation of the PQRI by CMS, which began in mid-CY 2007
- Authorized for continuation in CY 2008 by Medicare, Medicaid, and SCHIP Extension Act of 2007

A CMS-established voluntary quality reporting program

- To promote high-quality care and avoid unnecessary costs to Medicare program
- Provides financial incentive for eligible professionals to participate (goes beyond physicians to other health professionals)

Physician Payment

- 1.5% of total allowed charges for covered services payable under the Medicare Physician Fee Schedule

PQRI Measures

74 total measures in 2007

119 total measures in 2008 plus 2 "structural measures" for HIT adoption/use (i.e., electronic health records & electronic prescribing)

Examples of 2008 measures:

- diabetes care
- perioperative care
- stroke & stroke rehabilitation
- chronic kidney disease
- screening and/or therapy for conditions such as risk for falls, osteoporosis, mammographies for breast cancer & clinical depression

Method of reporting is via claims - no need to enroll or express intent to participate

CMS representatives will describe system at a future meeting.

National Evidence on Payment Initiatives

- As of July 2006, over half of state Medicaid programs had implemented a P4P program, with another 15 expecting implementation w/in a few years
- Bridges to Excellence programs implemented or being implemented in 16 states, within states reach limited
- Little comprehensive information on numbers of plans, physicians, or consumers involved in these initiatives nationwide
  - From 2005, HSC "while P4P has created a nationwide buzz...most initiatives are still on the drawing board")
  - Appears that reporting initiatives and tiered approaches are somewhat common, but P4P still less so
    - Premera BCBS of WA has P4P contract with large oncology practice
    - Highmark BCBS of PA programs for diabetes, CAD, COPD, and asthma
    - Aetna programs in DC for diabetes and cardiac care

Approaches by Maryland Insurers

Major insurers at varying stages vis-à-vis quality-based programs

- Designation or tiering programs have been implemented by UHC and Aetna
  - Differ in—
    - No. of specialties varies
    - Measures
    - Incentives
- Only CareFirst has incorporated quality into payment, and just in implementation stages

CareFirst BCBS

BCBSNCA and BCBSMD—

- progression of quality-based programs from early 90s
- Primary Care Physician Recognition Program, early P4P program, just phased out

CareFirst Quality Rewards (P4Q): Introduced in 2008, new reimbursement effective 2009

(endorsed by Bridges to Excellence)

- Which physicians affected?
  - Voluntary
  - Limited to pediatrics, family practice, internal medicine, and internal medicine subspecialties, w/ phase-in for others
  - Must be participating in specific networks and have sufficient claims volume

CareFirst Quality Rewards, cont.

- What is assessment based on?
  - Measures of effectiveness (quality) & efficiency (affordability)
  - 11 quality measures, 5 service-oriented business practices (e.g., maint. of board certification, use of EMR, diabetes physician recognition, PQRI participation)
  - Measures from administrative data as well as national programs, such as NCQA, CMS, specialty boards
  - Individual- and group-level measures, but administered at individual level
- Reimbursement based on earned points
  - Results shared with physicians annually
  - Measures translate into fee schedule changes
  - Reimbursement level up to 7% of base fee schedule

UnitedHealthcare

UnitedHealth Premium Designation Program:

- National program for performance transparency and improvement
- Physician recognition program
- 21 specialties
- Annual evaluation—
  - Analyzes claims to examine treatment practices for common conditions
  - Quality first (one star, evidence-based medicine guidelines), then efficiency (two stars, costs for episodes of care)
- Nationally, 38%-48% of physicians get two stars; episode cost is 10-23% lower than market average

UHC's P4P, not yet deployed in MD

UnitedHealth Practice Rewards:

- National pilot P4P program
- 1+ provider in practice must hold premium designation
- Automatic fee-schedule enhancements
- Domains of
  - clinical quality,
  - risk-adjusted episode efficiency, and
  - administrative efficiency
- Applicable across products

Aetna

Aexcel Quality Enhancement: tiered product, since 2003

- Physicians in 12 specialties
  - First, is claims volume sufficient?
  - Second, are clinical criteria met? e.g., 30-day re-admit rate, adverse events, preventive screenings
  - Third, how efficient compared to local peers?
- Approximately 60-65% of physicians in Aexcel network
- Consumers using these physicians face reduced co-pay

Aetna has no P4P in Maryland

Implemented elsewhere in US, selected locations based on employer demand

Issues with P4P

Physician buy-in is critical:

- Physicians on board in principle, but the devil is in the details…
  - Are measures and process transparent?
  - Are claims-based measures accurate?
  - Does each plan have different measures?
  - Are payment incentives large enough?
  - Problem of attribution if patients visit multiple providers

Concerns from consumer perspective:

- Opportunity for selection bias (incentive to avoid/disenroll unhealthy or uncooperative patients)—can measures be selected to avoid this?
- Potential to focus on measures with $$ attached to the detriment of other important aspects of care

Doctor Ranking Model Code

Consumer protection mechanism that sets standards for insurance companies' physician performance measurement and tiering systems

Created by NY Attorney General Andrew Cuomo

- in consultation w/AMA & other physician and consumer organizations

Stems from investigations into insurer ranking systems believed to be potentially deceptive

- Intended to strike fair balance between interests of physicians, patients & insurers
- Core principles of settlements w/insurers: accuracy & transparency of information, and oversight of the process

Under the code, insurers will:

- Ensure rankings based on measures of both cost-efficiency and quality of performance, i.e., not based solely on cost
- Use established national standards to measure quality
- Ensure accurate physician comparisons, i.e., risk adjustment, valid sampling
- Disclose program design, ranking process to consumers & doctors
- Provide process for consumer complaints & doctoral appeals
- Retain an oversight monitor to oversee compliance with the code

Insurer Settlements to Date

As of Dec. 2007, 7 insurers had adopted the Code:

- CIGNA
- Aetna
- Empire Blue Cross and Blue Shield (part of Wellpoint)
- UnitedHealthcare
- GHI/HIP (NY-based)
- MVP Healthcare/Preferred Care
- Independent Health Association, Inc. (Buffalo-based)

CIGNA, Aetna, UnitedHealthcare & Wellpoint will apply the principles of the Model Code nationwide

- Implications for consumers and physicians in Maryland who contract with/insured by these carriers (Aetna Aexcel and UHC Premium Designation)

Remaining issues for quality-based payment

- **Can risk adjustment systems appropriately account for differences across patients?**
  - Severity of illness and adequacy of risk adjustment
  - What about patient preferences?
  - Effects on access to care—do low-income patients use more resources?
- **How to measure performance?**
  - Process vs. outcome measures (or both?)
  - At individual level or across providers (or both?)
  - Level of performance vs. performance improvements
- **How do incentives get distributed?**
  - Payments from insurers to groups, and from groups to individuals
  - How do physicians behave when faced by systems from different insurers?

Issues, continued

- **Is more than one type of payment needed to account for different types of service needs?**
  - Primary care vs. specialty?
  - Acute vs. chronic care?
- **How do costs of implementation get covered?**
  - Payment to cover investment in infrastructure for recordkeeping?
  - Or for administrative costs of reporting? (Are these 'extra' costs or are they directly related to improving quality?)

Questions and Discussion